EXHIBIT 9
DATE 3/26/09
SB SB 406

SB 406

05/07/96 09:52 MT EQC/FISCAL DIV → 4067827403 NO.036 D

Kelleher

Legislative Fiscal Analyst
CLAYTON SCHENCK

Room 105 · State Cap
P.O. Box 2017
Helena, Montana 59620-17
(406) 444-2
FAX (406) 444-30

STATE OF MONTANA
Office of the Legislative Fiscal Analyst

FAX TRANSMISSION COVER SHEET

DATE: 5/7/96

TO: Mr. Bob Kelleher FAX #(406) 782-1715

FROM: Joanne Chanen, Legislative Fiscal Analyst (449-5387)

05/07/96 09:52 MT EQC/FISCAL DIV → 4067827403

TITLE X DOLLARS EXPENDED

	SFY 93	SFY 94	SFY 95	SFY 96	
Intermountain Planned Parenthood					= 625,418 ←
BILLINGS	$134,178	$157,595	$168,143	$165,502	Bridger Clinic
BOZEMAN	$89,073	$106,891	$103,069	$103,553	
BUTTE	$57,442	$61,539	$62,476	$62,199	
GLENDIVE	$15,279	$16,704	$16,304	$16,630	Dawson Cty Fam Plann
GREAT FALLS	$72,022	$70,134	$77,118	$75,270	Plan. Parenthood of G.F.
HAMILTON	$8,242	$8,520	$9,382	$9,227	Ravalli Cty Fam Plan
HAVRE	$19,650	$24,685	$25,538	$25,572	Hill " " "
HELENA	$40,639	$41,896	$43,360	$39,555	
KALISPELL	$39,938	$43,235	$44,725	$43,103	Flathead " " "
LEWISTOWN	$11,095	$11,888	$13,200	$13,277	Central Montana " "
LIBBY	$15,529	$15,889	$16,881	$17,762	Lincoln Cty Fam Plan
MILES CITY	$18,002	$23,184	$19,553	$17,895	Custer " " "
MISSOULA	$101,753	$118,621	$121,706	$131,224	
POLSON	$11,158	$12,000	$12,770	$13,561	Lake " " "
TOTAL	$634,000	$714,781	$734,225	$734,530	

= 917,536

IIAM PROTOCOL

FETAL KIDNEYS

C1 ←

DR. BURROW/DR. WILSON

Tissue Use: Molecular regulation of cellular differentiation in renal development.

Mailing Address:
Christopher Burrow, M.D.
Assistant Professor of Medicine
Hunterian 217
The Johns Hopkins University
School of Medicine
725 N. Wolfe St.
Baltimore, MD. 21205

10/92
Johns Hopkins School of Med
720 Rutland-Ross 447
Baltimore, MD
76 - Wilson 21205
(410) 614-0068 - Burrow

Shipping Address:
Attn. Dr. Chris Burrow
Johns Hopkins University
School of Medicine
1915 E. Madison St.
Baltimore, MD. 21205

Phone: Day: ~~(301) 955-0457~~ Night: (301) 239-4301
Fax: (301) 955-0485

Constraints: Prenatal 14-22 weeks. Remove and prepare for shipping within 24 hours after preparation under STERILE conditions. No contagious disease screen required. **Please do not provide any identification information.**

Prep.: Collins solution.

Quantity: 6/month starting 7/23/90.

C2 ←

Shipping: Ship fresh on wet ice. Next day within 24hrs.
FX Acct. # 133-025-499

Jeff
Kidneys 17wks 5/94
fresh-Super

Stephanie Tucker
brain in LN 2/94
lungs "
thigh muscle" 4/94

4/97

CONFIDENTIAL PROTOCOL

Thompson, Carolann
Zeneca Pharmaceuticals

Brain (Whole)

Mailing Address:
Dr. Thompson, Carolann
Zeneca Pharmaceuticals
1800 Concord Pike, AW-146
Wilmington De 19897

Shipping Address:
(same)

same
same

Phone: Day: 302-8867339 Other:302-886-7339

Fax# 302-886-5767

Ex D ←

Tissue: -**Brain (Whole), Both cortical hemispheres intact, if possible 16-22±wks**
-DMEM
-Wet ice, .

Preservation: **Fresh shipped on wet ice; identify buffer or media constituents below**

Contraindications:
no congenital abnormalities, neoplastic

Shipping: **Fresh, wet ice**

Tissue Use/Significance: **Characterization of Human Microglia in Neuroinflammation. Increasing the breadth of knowledge for this unique cell type will produce potential points of pharmacologic intervention for degenerative diseases affecting the central and/or peripheral nervous system, for which limited treatments are available now.**

M. McCUNES — SYSTEMIX

Susan Nicholas
3460 Bay Shore Rd
Palo Alto CA 94303
415-856-3400

SYSTEMIX'S FETAL TISSUE CRITERIA TO LEAM

PROTOCOL 9/90

Ed. 5025

FOR ALL TISSUE REQUESTED

Tissue Requested - Tissue should be removed and prepared under aseptic conditions within a maximum of ten (10) minutes after circulation has stopped

Shipping - Tissue is to be sent in media provided by Systemix and must be kept cold, 4°C. Use crushed ice. Do not freeze.

Consent Verification - We require that the consent form include the information that the tissue is for research purposes which may lead to commercial applications.

~~Contagious Disease Screening - AIDS, Hepatitis B~~

Donor Information Requested - race, congenital abnormalities (where known), sex of fetus (where known)

Contraindications: history of ARC, AIDS, Hepatitis B infection, intravenous drug abuse, prostitution, narcotic abuse, hemophilia (in father)

Saturday Courier
World Courier 800-221-66
Sup Acct # 442-435
Do 9/90
THYMUS* or LIVER
ARM TO HAVE LEG

FOR INDIVIDUAL TISSUE REQUESTED

TISSUE	TYPE	GEST AGES	AMOUNT	MAX. QUANTITY//SITE
Thymus* or Liver*	Fetal	>18 wks	Whole	3-5//511
Liver*	Fetal	>18 wks	Whole	3-5//511
Mesentery	Fetal	>18 wks	Whole	3-5//511
Leg/Arm Bone	Fetal	>18 wks	Both**	6//511
Spleen	Fetal	>18 wks	Whole	Upon Request

SPLEEN on request

*We need liver or thymus cells from each donor for our analyses. We prefer thymus over liver to accompany each donor. Do not send both unless otherwise requested.

**Arm bones (humeri) must accompany the leg bones (femurs and tibias). Do not send only humeri. The arms and legs do not have to be intact. They may be separated at the joints.

Additional Tissue: Criteria will be provided upon our permanent request.

#6 Leg/Arm bone
3-5 Mesentery
LIVER 3-5
THYMUS 3-5

(SLN 08-13-90)

EXE ←

*

The Breast Cancer Epidemic: Modeling and Forecasts Based on Abortion and Other Risk Factors

Patrick S. Carroll, M.A.

ABSTRACT

Using national cancer registration data for female breast cancer incidence in eight European countries—England & Wales, Scotland, Northern Ireland, the Irish Republic, Sweden, the Czech Republic, Finland, and Denmark—for which there is also comprehensive data on abortion incidence, trends are examined and future trends predicted. Seven reproductive risk factors are considered as possible explanatory variables. Induced abortion is found to be the best predictor, and fertility is also a useful predictor. Forecasts are made using a linear regression model with these explanatory variables. Previous forecasts using the same model and incidence data for years through 1997 for England & Wales are compared with numbers of cancers observed in years from 1998–2004 in an Appendix. The forecast predicted 100.5% of the cancers observed in 2003, and 97.5% of those observed in 2004.

The Challenge of Abortion for Epidemiologists in Female Breast Cancer Research

It is difficult for epidemiologists to discover women's abortion history. In any study the numbers of women who have had abortions may be underreported.[1]

National data on abortions in most countries tends to be deficient, with abortions underreported. Official abortion statistics in the United States[2] and France[3] are known to understate the numbers of legal induced abortions. The countries considered in this study are believed to have nearly complete official abortion counts.

The long lag time for the development of breast cancer magnifies the problem. The average age of diagnosis is over 60, while most abortions and live births occur at ages under 30. The modern increase in breast cancer incidence is obvious at ages over 45,[4] and Figure 1 for England & Wales shows the increase is small below age 45.

Abortion did not become legal in most Western countries until the 1970s, and earlier abortions among older women are not recorded. Consequently, the older women, whose breast cancer incidence is known, have abortions not detectable by a longitudinal study,[1,5,6] while the younger women, whose abortion history is known, tend to be too young to have experienced most of the modern increase in breast cancer.[1,5,7-11] Where the increased risk is apparent, even under age 40 in a study free of recall bias,[12] there is an acknowledged need to extend the study to women older than 40.

The long time lags, however, can be used to make long-term forecasts of cancer trends.

Trends

Since 1971 the overall increase has been 80%,[4] as shown for England & Wales in Figure 1.

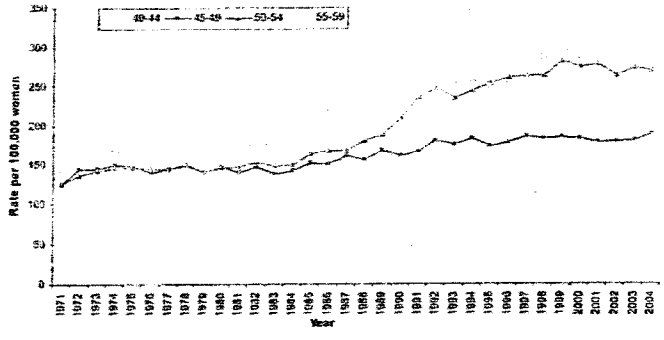

Figure 1. Average Yearly Rate of Incidence of Female Breast Cancer in England & Wales within Age Groups 40-44, 45-49, 50-54 and 55-59 from 1971-2004

Figure 2. Female Breast Cancer Mortality by Social Class: Proportional mortality ratios show increased reverse gradient across social class of women in England & Wales.

In contrast to other cancers, breast cancer is more common in upper-class women. This reverse gradient[13] is becoming steeper: see Figure 2. The reported standardized mortality ratio (SMR) in England for the highest social class I increased to 174 for the years 1997–2000, compared to an SMR of 169 for the years 1993–1996. As upper-class women have higher survival rates, the incidence gradient is steeper than the mortality gradient. Fertility differences do little to explain this gradient. However, the age at first birth among women who have children does provide a two-fold partial explanation. The least deprived women studied in a British survey[14] were found to have a greater preference for abortion when pregnant. Higher-class women have a later age at first birth[15] and consequently higher-class women have nulliparous abortions, which are more carcinogenic.

Local variation within countries can be examined in addition to international comparisons. The South East of England has more breast cancer than other parts of the British Isles.[16] It also has the highest abortion rate.[17] Ireland has the lowest rate of breast cancer

Ex F1

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Teenage suicide

among homosexual youths [6][7][8].

In 2004, 1,985 adolescents under the age of 20 committed suicide, an increase of 18% from the previous year.[9]

On September 6, 2007, the Centers for Disease Control and Prevention reported suicide rate in American adolescents (especially girls, 10 to 24 years old) increased 8% (2003 to 2004), the largest jump in 15 years. Specifically, in 2004 - 4,599 suicides in Americans ages 10 to 24, up from 4,232 in 2003, for a rate of 7.32 per 100,000 people that age. Before, the rate dropped to 6.78 per 100,000 in 2003 from 9.48 per 100,000 in 1990. The findings also reported that antidepressant drugs reduced suicide risk than increase it. Psychiatrists found that the increase is due to the decline in prescriptions of antidepressant drugs like Prozac to young people since 2003, leaving more cases of serious depression untreated. In a December 2006 study, The American Journal of Psychiatry said that a decrease in antidepressant prescriptions to minors of just a few percentage points coincided with a 14 percent increase in suicides in the United States; in the Netherlands, the suicide rate was 50% up, upon prescription drop.[10]

Suicide prevention

Promoting overall mental health among adolescents is key to reducing possible suicidal thoughts. Some people argue that limiting young people's access to lethal weapons, such as firearms, may be a pivotal deterrent. Some school-based youth suicide awareness programs exist to try to increase high-school students' awareness of the problem, provide knowledge about the behavioral characteristics of teens at risk, and describe available treatment or counseling resources. However, some research has shown that this may have an unintended negative effect of suggesting suicide as an option for teenagers [11].

When talking to a teenage person who is contemplating suicide, it is important to take the threat seriously. Seventy-five percent of all suicides give some warning of their intentions to a friend or family member.[12]

There are many methods of helping teenagers who are considering suicide. In order to help a suicidal person it is important to show the helper can be trusted and will listen. Seeing a doctor is widely recommended as well. A course doctors commonly take when presented with a young, suicidal patient is a combination of drug-based treatment (eg. imipramine or fluoxetine) with a 'talking-based' therapy, such as referral to a cognitive behaviour therapist. This kind of therapy concentrates on modifying self-destructive and irrational thought processes. [13] If you know someone who has suicidal thoughts, or you yourself are having suicidal thoughts, there are things that can be done to help. The most important thing you can do is take the suicidal thoughts seriously. Do not tell them that these thoughts will go away or they will get better on their own. The next thing you should do is notify an adult of the suicidal thoughts. This can be your parents, a teacher, a counselor, a doctor, etc. Tell someone who can help. You can also listen to them while they talk about their feelings. Never tell them not to worry about their feelings, or that the feelings will go away on their own and they will get better on their own. Never leave anyone alone that you feel may be in danger of hurting themselves. There are also hotlines, which can be used if needed. The hotline centers have trained professionals who can talk about problems and sort through their feelings (U.S.DHSS, 2006). If you know someone is suicidal there are things, which can serve as protective factors. This includes but is not limited to clinical care for those with psychological disorders, limited access to items that can be used to attempt suicide, a strong support system of friends, family, and health care personnel, help developing skills to cope with stressful situation, and a strong support system of religious beliefs (U.S.DHSS, 2006).

When trying to help a teenager who is considering suicide, it's important to try to find out what is troubling the person. Lack of parental interest in their teenage children may be considered a factor in teenage suicide: according to one study 90 percent of suicidal teenagers believed their families did not understand them.[14]

When confronted by a suicidal teen, it is often an unsuccessful strategy to try to argue them out of committing suicide, or attempt to make them feel guilty for considering suicide (e.g. "your family loves you so much, how could you think like this?"). This type of intervention can actually serve to alienate the child further. Instead, a better solution may consist of an exploration of the reasons why the teenager is so unhappy and feels that suicide is the best solution. The teenager's pediatrician will also be able to plan a suitable course of treatment, or make a psychiatric referral, if the teenager is willing to engage with the proposed treatment.

In a crisis situation professional help must be sought, either at hospital or a walk-in clinic. There are also several telephone help numbers for help on teenage suicide, depending on one's location (country/state). Also, emergency services should be contacted immediately, in case the teenager makes a suicide attempt.

DELEGATE PROPOSAL NO. 193

DATE INTRODUCED: FEB. 2, 1972

A PROPOSAL FOR A NEW
RIGHT TO BE BORN AND THE

BE IT PROPOSED BY THE
MONTANA:

Section 1. There shall
provide as follows:

"Section ___. A human fetus has
incurably ill have the right not to be kept alive by
dinary means."

INTRODUCED BY: /s/ Robert Lee

Notes of Decisions

rental consent 1

1 Parental consent

Creation of "referral system" whereby inors, for whom state declines to pro- e family planning services under Title [Public Health Service Act, § 1001 et q., as amended, 42 U.S.C.A. § 300 et q.] because no parental consent was provided, could be sent by state to non-governmental group which provides such services would not cure violation of Title X arising from imposing prior written parental consent requirement on unmarried minors seeking family planning services under Title X. Jane Does 1 through 4 v. State of Utah Dept. of Health, C.A.10 (Utah) 1985, 776 F.2d 253.

§ 300a–5. Voluntary participation by individuals; participation not prerequisite for eligibility or receipt of other services and information

The acceptance by any individual of family planning services or mily planning or population growth information (including edu- tional materials) provided through financial assistance under this bchapter (whether by grant or contract) shall be voluntary and all not be a prerequisite to eligibility for or receipt of any other rvice or assistance from, or to participation in, any other program the entity or individual that provided such service or information.

uly 1, 1944, c. 373, Title X, § 1007, as added Dec. 24, 1970, Pub.L. 91–572, 6(c), 84 Stat. 1508.)

HISTORICAL AND STATUTORY NOTES

vision Notes and Legislative Reports 1970 Acts. House Report No. 91–1472 d Conference Report No. 91–1667, see 1970 U.S.Code Cong. and Adm.News p. 5068.

LIBRARY REFERENCES

erican Digest System
Social Security and Public Welfare ⇐4.6, 4.10.
Key Number System Topic No. 356A.

rpus Juris Secundum
C.J.S. Social Security and Public Welfare §§ 10 to 11, 18.

ts and Treatises
17 Fed. Proc. L Ed Health, Education, and Welfare § 42:244.

WESTLAW ELECTRONIC RESEARCH

See WESTLAW guide following the Explanation pages of this volume.

§ 300a–6. Prohibition against funding programs using abortion as family planning method

None of the funds appropriated under this subchapter shall be used programs where abortion is a method of family planning.

uly 1, 1944, c. 373, Title X, § 1008, as added Dec. 24, 1970, Pub.L. 91–572, 6(c), 84 Stat. 1508.)